Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee **Benefit Plan**

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500-SF.

2017

OMB Nos. 1210-0110

1210-0089

This Form is Open to **Public Inspection**

Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) //OLNITZEK, ROWEKAMP, & DEMARCUS, P.S.C. 2c Sponsor's telephone number 859-491-4444 2d Business code (see instructions) OVINGTON, KY 41011 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number 3c Administrator's telephone number	Part I	Annual Report	t Identification Information							
A This return/report is for: a one-participant plan a foreign plan be first return/report destructions) a foreign plan be first return/report destructions be first return/report destructions destructions DFVC program DFVC progra	For calend	ar plan year 2017 or f	fiscal plan year beginning 01/01/2	2017 and ending 1	12/31/2017					
B This return/report is	A This re	turn/report is for:		list of participating employer information in a						
C Check box if filing under: Second Part Second Part			a one-participant plan	∐ a foreign plan						
C Check box if filing under:	B This ret	urn/report is	=							
Special extension (enter description) Part II Basic Plan Information—enter all requested information 1a Name of plan VOLNITZEK, ROWEKAMP & DEMARCUS, P.S.C. RETIREMENT PLAN 1c Effective date of plan O/10/1/987 2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) 2c Sponsor's telephone number RS9-491-4444 2d Business code (see instructions) 2c Sponsor's telephone number RS9-491-4444 2d Business code (see instructions) 3c Administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name Plan Name 5a 13 b Total number of participants at the beginning of the plan year. 5b 9 c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item). d(2) Total number of active participants at the beginning of the plan year (only defined contribution plans complete this item). 5d(2) 7 e Number of participants with terminated employment during the plan year with accrued benefits that were less 56 0			an amended return/report	a snort plan year return/report (less than 12 h	nontns)					
Part II Basic Plan Information—enter all requested information 1a Name of plan VOLNITZEK, ROWEKAMP & DEMARCUS, P.S.C. RETIREMENT PLAN 1c Effective date of plan O10/1/987 2a Plan sponsor's name (employer, if for a single-employer plan) O10/1/987 2a Plan sponsor's name (employer, if for a single-employer plan) O10/1/987 2a Plan sponsor's name (employer, if for a single-employer plan) O10/1/987 2b Employer Identification Number (EIN) 61-1098034 2c Sponsor's telephone number O59-491-4444 2d Business code (see instructions) O2 GREENUP STREET OVINGTON, KY 41011 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number O10/1/987 3c Administrator's telephone number O2 Administrator's	C Check	box if filing under:								
1b Three-digit plan number (PN) 001	Part II	Basic Plan Info	ormation—enter all requested int	formation						
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) //OLNITZEK, ROWEKAMP, & DEMARCUS, P.S.C. 2c Sponsor's telephone number 859-491-4444 2d Business code (see instructions) 541110 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number 6c Administrator's telephone number 6c Administrator's telephone number 6c Plan Name 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. 6 Sponsor's name 6 Plan Name 5a Total number of participants at the beginning of the plan year. 5b 9 6 Number of participants with account balances as of the end of the plan year. 6 Sold(1) Total number of active participants at the beginning of the plan year. 6 Number of participants with account balances as of the end of the plan year. 6 Number of participants at the end of the plan year. 6 Number of participants at the end of the plan year. 6 Number of participants with account balances as of the end of the plan year. 6 Number of participants with terminated employment during the plan year with accrued benefits that were less 6 Sold(1) 6 Sold(1) 7 Sold(2) 7 Sold(2) 7 Sold(2) 7 Sold(2) 7 Sold(3)	1a Name	of plan	·		plan number	001				
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) 70 LNITZEK, ROWEKAMP, & DEMARCUS, P.S.C. 2c Sponsor's telephone number 859-491-4444 2d Business code (see instructions) 541110 3a Plan administrator's name and address Same as Plan Sponsor. 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 4d PN 4d PN 5a 13 b Total number of participants at the beginning of the plan year. 5b 9 c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item). 4d(2) Total number of active participants at the end of the plan year. 6 Valon number of active participants at the end of the plan year. 6 Valon number of active participants at the end of the plan year. 6 Valon number of participants at the end of the plan year. 6 Valon number of participants at the end of the plan year. 6 Valon number of active participants at the end of the plan year. 6 Valon number of participants with account balances as of the end of the plan year. 6 Valon number of participants with account balances as of the end of the plan year. 6 Valon number of participants with account balances as of the end of the plan year. 6 Valon number of participants with account balances as of the end of the plan year. 7 Valon number of participants with account balances as of the end of the plan year. 8 Valon Number of participants with account balances as of the end of the plan year. 9 Valon Plan Number of participants with account balances as of the end of the plan year. 5 Valon Number of participants with account balances as of the end of the plan year. 5 Valon Number of participants with a					L					
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2C Sponsor's telephone number 885-491-44444 2d Business code (see instructions) 541110 3a Plan administrator's name and address Same as Plan Sponsor. 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year					2b Employer Identification Number					
3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's EIN 3c Administrator's telephone number 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year										
3b Administrator's EIN 3c Administrator's telephone number 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year					2d Business code	e (see instructions)				
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 5a 13 b Total number of participants at the beginning of the plan year					541	1110				
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 5a 13 b Total number of participants at the beginning of the plan year	3a Plan a	dministrator's name a	and address X Same as Plan Spor	nsor.	3b Administrator's	s EIN				
this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name C Plan Name 5a 13 b Total number of participants at the beginning of the plan year					3c Administrator's telephone number					
a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year					4b EIN					
Total number of participants at the beginning of the plan year	•		onsor's name, EIN, the plan name a	and the plan number from the last return/report.	4d DN					
b Total number of participants at the end of the plan year	•				4u PN					
b Total number of participants at the end of the plan year	5a Total	number of participant	s at the beginning of the plan year		. 5a	13				
C Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)					5b	9				
d(2) Total number of active participants at the end of the plan year	C Numb	er of participants with	account balances as of the end of	the plan year (only defined contribution plans	5c	8				
e Number of participants who terminated employment during the plan year with accrued benefits that were less	d(1) Tot	al number of active pa	articipants at the beginning of the pl	an year	5d(1)	11				
e Number of participants who terminated employment during the plan year with accrued benefits that were less	• •				5d(2)	7				
	e Numl	ber of participants who	o terminated employment during the	e plan year with accrued benefits that were less	5e	0				
Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.	Caution: A	A penalty for the late	or incomplete filing of this return	n/report will be assessed unless reasonable ca						
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.	SB or Sche	edule MB completed a	and signed by an enrolled actuary, a							

05/11/2018

05/11/2018

Date

Date

STEPHEN WOLNITZEK

STEPHEN WOLNITZEK

Enter name of individual signing as plan administrator

Enter name of individual signing as employer or plan sponsor

Filed with authorized/valid electronic signature.

Filed with authorized/valid electronic signature.

Signature of plan administrator

SIGN HERE

SIGN

HERE

Form 5500-SF 2017 Page **2**

6a b	Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)						X Yes	☐ No	
С	If you answered "No" to either line 6a or line 6b, the plan cannot the plan is a defined benefit plan, is it covered under the PBGC in If "Yes" is checked, enter the My PAA confirmation number from the	ot use Fo surance p	rm 5500-SF and mus rogram (see ERISA se	t instea ection 4	ad use 021)?	Form	5500. Yes No	Not dete	rmined
Pa	rt III Financial Information								
7	Plan Assets and Liabilities		(a) Beginning	of Year			(b) End	of Year	
а	Total plan assets	7a	242	23153				2984709	
b	Total plan liabilities	7b							
С	Net plan assets (subtract line 7b from line 7a)	7c	242	23153				2984709	
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	ıt			(b) 1	Total	
a	Contributions received or receivable from: (1) Employers	8a(1)		22036					
	(2) Participants	8a(2)	4	46507					
	(3) Others (including rollovers)	8a(3)							
b	Other income (loss)	8b	49	93038					
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						561581	
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d							
е	Certain deemed and/or corrective distributions (see instructions)	8e							
<u>f</u>	Administrative service providers (salaries, fees, commissions) 8f								
g	Other expenses 8g 0								
<u>h</u>	h Total expenses (add lines 8d, 8e, 8f, and 8g)							25	
<u> </u>	Net income (loss) (subtract line 8h from line 8c)	8i						561556	
	Transfers to (from) the plan (see instructions)	8j							
	t IV Plan Characteristics								
9a 	If the plan provides pension benefits, enter the applicable pension 2E 2F 2G 2J 2K 3D								
b	If the plan provides welfare benefits, enter the applicable welfare for	eature cod	es from the List of Pla	n Chara	acterist	ic Cod	es in the instr	uctions:	
Par	t V Compliance Questions								
10	During the plan year:				Yes	No		Amount	
а	Was there a failure to transmit to the plan any participant contribut described in 29 CFR 2510.3-102? (See instructions and DOL's V Program)	oluntary F	iduciary Correction	10a		X			
b	Were there any nonexempt transactions with any party-in-interest reported on line 10a.)	? (Do not i	include transactions	10a		X			
С				10c	X			5000	00
d	d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?			10d		Χ			
е	Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)			10e		X			
f	f Has the plan failed to provide any benefit when due under the plan?			10f		X			
g	Did the plan have any participant loans? (If "Yes," enter amount as	s of year-e	end.)	10g	X			15	26
h	If this is an individual account plan, was there a blackout period? (2520.101-3.)	•		10h		X			
i	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.101			10i					

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Part	VI Pension Funding Compliance									
11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and line 11a below)										
11a	11a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40									
12	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)									
а	a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver									
lf y	you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.									
b	Enter the minimum required contribution for this plan year	12b								
С	Enter the amount contributed by the employer to the plan for this plan year	12c								
d	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)	12d								
е	Will the minimum funding amount reported on line 12d be met by the funding deadline?	. [Yes	No	N/A					
Part '	VII Plan Terminations and Transfers of Assets									
13a	Has a resolution to terminate the plan been adopted in any plan year?		Ye	s X N	0					
	If "Yes," enter the amount of any plan assets that reverted to the employer this year	13a								
b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?										
c If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)										
1	3c(1) Name of plan(s): 13c(2) EIN(s)		13c(3) PN(s)					

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500-SF.

OMB Nos. 1210-0110 1210-0089

2017

This Form is Open to Public Inspection

Pi	art I Annual Re	port Identification Information	1						
For	calendar plan year 2017	or fiscal plan year beginning	01/01/2017	and ending	12/31/20	17			
_	This return/report is for: This return/report is:	a single-employer plan a one-participant plan the first return/report an amended return/report	a list of participating a foreign plan the final return/repo	employer information in	ployer) (Filers checking this box must attach tion in accordance with the form instructions.) an 12 months)				
C	Check box if filing under	Form 5558	automatic extension		r	program			
Pa	rt II Basic Plan	Information enter all requested	Linformation	· · · · · · · · · · · · · · · · · · ·					
	Name of plan	kamp & DeMarcus, P.S.C. Re			1b Three-dig plan num (PN) ► 1c Effective	ber 001			
2a	Mailing Address (included City or town, state or p	employer, if for a single-employer plan de room, apt., suite no. and street, or P province, country, and ZIP or foreign po- lekamp, & DeMarcus, P.S.C.	.O. Box)	istructions)	01/01/ 2b Employer (EIN) 6 2c Sponsor's (859)	•			
3a	US Covington KY 410 Plan administrator's na	11 ame and address X Same as Plan Sp	consor		3b Administr	ator's EIN ator's telephone number			
		I of the plan sponsor or the plan name I n sponsor's name, EIN, the plan name			4b EIN 4d PN				
	Total number of partici	pants at the beginning of the plan year			. 5a	13			
b		pants at the end of the plan year				9			
С	Number of participants	with account balances as of the end o	f the plan year (only define	ed contribution plans	F	8			
d(Total number of active	ve participants at the beginning of the p	lan year	***************************************	. 5d(1)	11			
d (2	2) Total number of activ	ve participants at the end of the plan ye	ar		5d(2)	7			
е	Number of participants less than 100% vested	who terminated employment during th				0			
Und SB bel	der penalties of perjury or Schedule MB compli ief, it is true, correct, an GN Signature of plan		uctions, I declare that I ha	ve examined this return/	report, including, i ort, and to the bes zek	f applicable, a Schedule st of my knowledge and			
450 State (25)	GN ERE Signature of emp	ployer/plan sponsor	Date	Enter name of individ	ual signing as emi	oloyer or plan sponsor			

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6a	Were all of the plan's assets during the plan year invested in eligible	e assets?	(See instructions.)					XYes	□No	
b	Are you claiming a waiver of the annual examination and report of a	ın indepen	dent qualified public acco	untan	t (IQF	PA)				
	under 29 CFR 2520.104-46? (See instructions on waiver eligibility a							X Yes	□No	
	If you answered "No" to either line 6a or line 6b, the plan cannot							,		
С	If the plan is a defined benefit plan, is it covered under the PBGC in	-	-						letermined	
	If "Yes" is checked, enter the My PAA confirmation number from the	e PBGC pi	emium filing for this year					(See instru	ictions.)	
Pa	Irt III Financial Information								iri	
7	Plan Assets and Liabilities		(a) Beginning o	f Yea	r	Т		(b) End of Year		
а	Total plan assets	7a	2,42	23,1	53			2,984	,709	
b	Total plan liabilities	7b								
С	Net plan assets (subtract line 7b from line 7a)	7c	2,42	23,1	53			2,984	,709	
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount				i.	(b) Totai		
а	Contributions received or receivable from: (1) Employers	8a(1)	,	22,0	36					
	(2) Participants	8a(2)		16,5		3/10/			36366666	
	(3) Others (including rollovers)	1		,.	·····	_ 1010111 - 15116 - 15116				
b	Other income (loss)	8b	49	93,0	38					
c	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c			18 (21 (25))	561,581				
d	Benefits paid (including direct rollovers and insurance premiums		- manual common activi or modosci (dos milores mett	Utivipales	132 b Co Stration o					
	to provide benefits)	8d				8101 2010				
e	Certain deemed and/or corrective distributions (see instructions)							koksisiningulapadena waanamama		
<u>f</u>	Administrative service providers (salaries, fees, commissions)	8f			25	120 (6) 120 (6)				
9_	Other expenses	8g		Ukstoket	0				OF	
<u>h</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		9494491981 14411811481	OMOGRADA OMOGRADA			F.C.1	25	
<u>+</u>	Net income (loss) (subtract line 8h from line 8c)	8i				561,556				
J Do	Transfers to (from) the plan (see instructions) Intil Plan Characteristics	<u>8j</u>				iikiii	disignili (ija			
T	· · · · · · · · · · · · · · · · · · ·		f 0 1: 6 CDL 0	,			,			
Ja	If the plan provides pension benefits, enter the applicable pension for 2E 2F 2G 2J 2K 3D	eature coo	es from the List of Plan C	narac	teristi	ic Co	aes in ti	ne instructions;		
	The state of the s									
b	If the plan provides welfare benefits, enter the applicable welfare fea	ature code	s from the List of Plan Ch	aracte	eristic	Code	es in the	e instructions:		
Pa	Int V Compliance Questions									
10	During the plan year:				Yes	No	N/A	Amount		
a		tions withi	n the time period		163	INO		Allioune		
	described in 29 CFR 2510.3-102? (See instructions and DOL's Vo		·							
	Program)			10a		х		***************************************		
b	The many memoral per transcaptions many party in interest	? (Do not i	nclude transactions	441		١,,				
	reported on line 10a.)			10b		Х	24569765 26116455		.000	
d				10c	<u> </u>		000000000 000000000		500,000	
u	by fraud or dishonesty?			10d		x				
е	y	ner person	s by an insurance				1000000	•		
	carrier, insurance service, or other organization that provides som	e or all of	the benefits under	10e		x	0.000			
- f	the plan? (See instructions.) f Has the plan failed to provide any benefit when due under the plan?						308317978B 369301336			
	The state of the s					х				
<u>9</u> h	g Did the plan have any participant loans? (If "Yes," enter amount as of year end.)				Х			yannan nasayare saac	1,526	
	If this is an individual account plan, was there a blackout period? (2520.101-3.)			10h		х				
i	If 10h was answered "Yes," check the box if you either provided the						1000			
	exceptions to providing the notice applied under 29 CFR 2520.101	I-3	***************************************	10i			関節等			

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Par	Pension Funding Compliance					
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete S (Form 5500 and line 11a below)		SB	☐ Yes	X No	
11a	Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40	11a			_	
12	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or sec ERISA?			☐ Yes	X No	
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)					
а 	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, a granting the waiver	and ente Da		of the letter Year	ruling	
ify	ou completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.					
b	Enter the minimum required contribution for this plan year.	12b				
. с	Enter the amount contributed by the employer to the plan for the plan year	12c				
d	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)	12d				
e	e Will the minimum funding amount reported on line 12d be met by the funding deadline? Yes No N/A					
Par	Plan Terminations and Transfers of Assets					
13a	Has a resolution to terminate the plan been adopted in any plan year?		Yes	X No		
	If "Yes," enter the amount of any plan assets that reverted to the employer this year	13a				
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?			es 🗴 l	No	
С	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan which assets or liabilities were transferred. (See instructions.)	(s) to				
1	3c(1) Name of plan(s): 13c(2) E	IN(s)		13c(3) P	N(s)	
			111111111111111111111111111111111111111			